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| **Assistive Technology Assessment Form** | | | | | | |
| **Child Demographics** | | | | | | |
| **Child Name** | **Date of Birth** | | **Assessment Date** | **Diagnosis Code (ICD-10)** | **Insurance Information** | |
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| **Assistive Technology Assessment Team Members** | | | | | | |
| **Provider Name** | **Provider Code** | | **Provider Type** | | **Medicaid ID** | |
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| **Reason for Assistive Technology is being recommended:** | | | | | | |
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| **Child’s goals and outcomes that will be addressed with this technology:**  *(Please include the child’s IFSP outcome and date of the IFSP)* | | | | | | |
|  | | | | | | |
| **How will assistive technology increase, maintain, or improve the child’s functional capabilities?** | | | | | | |
|  | | | | | | |
| **Other funding sources (To be completed by the SC)** | | | | | | |
|  | | | | | | |
| **Please describe the training plan for the parents and caregivers:** | | | | | | |
|  | | | | | | |
| **Assessor Name** | | **Signature** | | | | **Date** |
|  | |  | | | |  |
| **Service Coordinator** | | **Signature** | | | | **Date** |
|  | |  | | | |  |